The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals, and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this proposed notice would not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis *if a rule may have* a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this proposed notice would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed notice would have no consequential effect on the governments mentioned or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet *when it promulgates a proposed rule (and subsequent final rule)* that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed notice and have determined that it would not have a substantial effect on State or local governments.

In accordance with the provisions of Executive Order 12866, this document was reviewed by the Office of Management and Budget.

Authority: Sections 1816(a), 1833, 1842(a), 1861, 1862(a)(1)(A), and 1862(a)(7) of the Social Security Act (42 U.S.C. 1395h(a), 1395l, 1395u(a), 1395x, 1395y(a)(1)(A), and 1395y(a)(7))

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 23, 2003.

Thomas A Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: September 16, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–31573 Filed 12–23–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1226–GNC]

RIN 0938–ZA44

Medicare Program; Criteria and Standards for Evaluating Intermediary, Carrier, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carrier Performance During Fiscal Year 2004

AGENCY: Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS).

ACTION: General notice with comment period.

SUMMARY: This notice describes the criteria and standards to be used for evaluating the performance of fiscal intermediaries, carriers, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) regional carriers in the administration of the Medicare program beginning on the first day of the first month following publication of this notice in the **Federal Register**. The results of these evaluations are considered whenever we enter into, renew, or terminate an intermediary agreement, carrier contract, or DMEPOS regional carrier contract or take other contract actions, for example, assigning or reassigning providers or services to an intermediary or designating regional or national intermediaries. We are requesting public comment on these criteria and standards.

DATES: *Effective Date:* The criteria and standards are effective January 2, 2004.

Comment Period: Comments will be considered if we receive them at the appropriate address as provided below no later than 5 p.m. (EDT) on January 23, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1226–GNC. Because of staff and resource limitations, we cannot accept comments by facsimile (fax) transmission. Mail written comments (one original and two copies) to the following address:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1226–GNC, PO Box 8016, Baltimore, MD 21244–8016.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC, 20201 or Room C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Sue Lathroum, (410) 786–7409.

SUPPLEMENTARY INFORMATION: In several instances, we identify a Medicare manual as a source of more detailed requirements. Medicare fee-for-service contractors have copies of the various Medicare manuals referenced in this notice. Members of the public also have access to our manual instructions.

Medicare manuals are available for review at local Federal Depository Libraries (FDLs). Under the FDL Program, government publications are sent to approximately 1,400 designated public libraries throughout the United States. To locate the nearest FDL, individuals should contact any public library.

In addition, individuals may contact regional depository libraries that receive and retain at least one copy of nearly every Federal government publication, either in printed or microfilm form, for use by the general public. These libraries provide reference services and interlibrary loans; however, they are not sales outlets. Individuals may obtain information about the location of the nearest regional depository library from any library. Information may also be obtained from the following Web site: *http://www.cms.hhs.gov/manuals.*

Finally, all of our regional offices (ROs) maintain all Medicare manuals for

public inspection. To find the location of our nearest available RO, you may call the individual listed at the beginning of this notice. That individual can also provide information about purchasing or subscribing to the various Medicare manuals.

Response to Public Comments: Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are unable to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the Comment Period section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble of that document.

Inspection of Public Comments: Comments received timely are available for public inspection or they are processed beginning approximately 3 weeks after the close of the comment period, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7197.

I. Background

A. Part A—Hospital Insurance

Under section 1816 of the Social Security Act (the Act), public or private organizations and agencies participate in the administration of Part A (Hospital Insurance) of the Medicare program under agreements with us. These agencies or organizations, known as fiscal intermediaries, determine whether medical services are covered under Medicare, determine correct payment amounts and then make payments to the health care providers (for example, hospitals, skilled nursing facilities (SNFs), and community mental health centers) on behalf of the beneficiaries. Section 1816(f) of the Act requires us to develop criteria, standards, and procedures to evaluate an intermediary's performance of its functions under its agreement.

Section 1816(e)(4) of the Act requires us to designate regional agencies or organizations, which are already Medicare intermediaries under section 1816 of the Act, to perform claim processing functions for freestanding Home Health Agency (HHA) claims. We refer to these organizations as Regional Home Health Intermediaries (RHHIs). See § 421.117 and the final rule published in the **Federal Register** on May 19, 1988 (53 FR 17936) for more details about the RHHIs.

The evaluation of intermediary performance is part of our contract management process. These evaluations need not be limited to the current fiscal year (FY), other fixed term basis, or agreement term.

B. Part B Medical Insurance

Under section 1842 of the Act, we are authorized to enter into contracts with carriers to fulfill various functions in the administration of Part B, Supplementary Medical Insurance of the Medicare program. Beneficiaries, physicians, and suppliers of services submit claims to these carriers. The carriers determine whether the services are covered under Medicare and the amount payable for the services or supplies, and then make payment to the appropriate party.

Under section 1842(b)(2) of the Act, we are required to develop criteria, standards, and procedures to evaluate a carrier's performance of its functions under its contract. Evaluations of Medicare fee-for-service contractor performance need not be limited to the current FY, other fixed term basis, or contract term. The evaluation of carrier performance is part of our contract management process.

C. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carriers

In accordance with section 1834(a)(12) of the Act, we have entered into contracts with four DMEPOS regional carriers to perform all of the duties associated with the processing of claims for DMEPOS, under Part B of the Medicare program. These DMEPOS regional carriers process claims based on a Medicare beneficiary's principal residence by State. Section 1842(a) of the Act authorizes contracts with carriers for the payment of Part B claims for Medicare covered services and items. Section 1842(b)(2) of the Act requires us to publish in the **Federal Register** criteria and standards for the efficient and effective performance of carrier contract obligations. Evaluation of Medicare fee-for-service contractor performance need not be limited to the current FY, other fixed term basis, or contract term. The evaluation of DMEPOS regional carrier performance is part of our contract management process.

D. Development and Publication of Criteria and Standards

In addition to the statutory requirements, §§ 421.120 and 421.122 provide for publication of a **Federal Register** notice to announce criteria and standards for intermediaries before implementation. Section 421.201 provides for publication of a **Federal Register** notice to announce criteria and standards for carriers before implementation. The current criteria and standards for intermediaries, carriers, and DMEPOS regional carriers were published in the February 28, 2003 final rule (68 FR 9681).

To the extent possible, we make every effort to publish the criteria and standards before the beginning of the Federal FY, which is October 1. If we do not publish a **Federal Register** notice before the new FY begins, readers may presume that until and unless notified otherwise, the criteria and standards that were in effect for the previous FY remain in effect.

In those instances in which we are unable to meet our goal of publishing the subject **Federal Register** notice before the beginning of the FY, we may publish the criteria and standards notice at any subsequent time during the year. If we publish a notice in this manner, the evaluation period for the criteria and standards that are the subject of the notice will be effective on the first day of the first month following publication. Any revised criteria and standards will measure performance prospectively; that is, we will not apply new measurements to assess performance on a retroactive basis.

It is not our intention to revise the criteria and standards that will be used during the evaluation period once this information has been published in a **Federal Register** notice. However, on occasion, either because of administrative action or congressional mandate, there may be a need for changes that have a direct impact on the criteria and standards previously published, or that require the addition of new criteria or standards, or that cause the deletion of previously published criteria and standards. If we must make these changes, we will publish an amended **Federal Register** notice before implementation of the changes. In all instances, necessary manual issuances will be published to ensure that the criteria and standards are applied uniformly and accurately. Also, as in previous years, this **Federal Register** notice will be republished and the effective date revised if changes are warranted as a result of the public comments received on the criteria and standards.

II. Analysis of and Response to Public Comments Received on FY 2003 Criteria and Standards

We received no comments in response to the February 28, 2003 **Federal Register** general notice with comment.

III. Criteria and Standards—General

Basic principles of the Medicare program are to pay claims promptly and accurately and to foster good beneficiary and provider relations. Contractors must administer the Medicare program efficiently and economically. The goal of performance evaluation is to ensure that contractors meet their contractual obligations. We measure contractor performance to ensure that contractors do what is required of them by statute, law, regulation, contract, and our directives.

We have developed a contractor oversight program for FY 2004 that outlines expectations of the contractor; measures the performance of the contractor; evaluates the performance against the expectations; and provides for appropriate contract action based upon the evaluation of the contractor's performance.

As a means to monitor the accuracy of Medicare FFS payments, we have established the Comprehensive Error Rate Testing (CERT) program—which produces error rates for claims payment decisions made carriers, DMERCs, and FIs. Beginning in November 2003, the CERT program produced claims payment error rates for each individual carrier and DMERC. (FI—specific rates will be available the following year.) These rates measure not only how well contractors are doing at implementing automated review edits and identifying which claims to subject to manual medical review but also measure the impact of the contractor's provider outreach/education and effectiveness of the contractor's provider call centers. As such, we will utilize these contractor-specific error rates as a means to evaluate a contractor's performance.

Several times throughout this notice, we refer to the ''readability'' of letters, decisions, or correspondence that are going to Medicare beneficiaries from intermediaries or carriers. In those instances, ''readability'' is defined as being below the 8th grade reading level unless it is obvious that an incoming request from the beneficiary contains language written at a higher level. In these cases, the readability level is tailored to the capacities and circumstances of the intended recipient.

In addition to evaluating performance based upon expectations for FY 2004, we may also conduct follow-up evaluations throughout FY 2004 of areas in which contractor performance was out of compliance with statute, regulations, and our performance expectations during prior review years and thus required the contractor to submit a Performance Improvement Plan (PIP).

We may also utilize Statement of Auditing Standards–70 (SAS–70) reviews as a means to evaluate contractors in some or all business functions.

In FY 2001, we established the Contractor Rebuttal Process as a commitment to continual improvement of contractor performance evaluation (CPE). We will continue the use of this process in FY 2004. The Contractor Rebuttal Process provides the contractors an opportunity to submit a written rebuttal of CPE findings of fact. Whenever we conduct an evaluation of contractor operations, contractors have 7 calendar days from the date of the CPE review exit conference to submit a written rebuttal. The CPE review team or, if appropriate, the individual reviewer will consider the contents of the rebuttal before the issuance of the final CPE report to the contractor.

The FY 2004 CPE for intermediaries and carriers is structured into five criteria designed to meet the stated objectives. The first criterion is ''Claims Processing'' which measures contractual performance against claims processing accuracy and timeliness requirements as well as activities in handling appeals. Within the Claims Processing Criterion, we have identified those performance standards that are mandated by legislation, regulation, or judicial decision. These standards include claims processing timeliness, the accuracy of Medicare Summary Notices (MSNs), the appropriateness of determinations reversed by an administrative law judge (ALJ), the timeliness of intermediary reconsiderations, reviews and hearings and the timeliness of carrier reviews and hearings, and the readability of carrier reviews. Further evaluation in the Claims Processing Criterion may include, but is not limited to, the accuracy of claims processing, the percent of claims paid with interest, and the accuracy of reconsiderations, reviews, and hearings.

The second criterion is ''Customer Service'' which assesses the adequacy of the service provided to customers by the contractor in its administration of the Medicare program. The mandated standard in the Customer Service Criterion is the need to provide beneficiaries with written replies that are responsive, that is, provide in detail the reasons for a determination when a beneficiary requests this information, have a customer-friendly tone and clarity, and are at the appropriate reading level. Further evaluation of services under this criterion may include, but is not limited to, the timeliness and accuracy of all correspondence both to beneficiaries and providers; monitoring of the quality of replies provided by the contractor's customer service representatives (quality call monitoring); beneficiary and provider education, training, and outreach activities; and service by the contractor's customer service representatives to beneficiaries who come to the contractor's facility (walk-in inquiry service).

The third criterion is ''Payment Safeguards'' that evaluates whether the Medicare Trust Fund is safeguarded against inappropriate program expenditures. Intermediary and carrier performance may be evaluated in the areas of Medical Review (MR), Medicare Secondary Payer (MSP), Overpayments (OP), and Provider Enrollment (PE). In addition, intermediary performance may be evaluated in the area of Audit and Reimbursement (A&R).

In FY 1996 the Congress enacted the Health Insurance Portability Act, Medicare Integrity Program giving us the authority to contract with other than, but not excluding, Medicare carriers and intermediaries to perform certain program safeguard functions. In situations where one or more program safeguard functions have been contracted to another entity, we may evaluate the flow of communication and information between a Medicare fee-for-service contractor and the Payment Safeguard Contractor. All Benefit Integrity functions have been transitioned from intermediaries and carriers to the Program Safeguard Contractors, but three DMERCs will continue to handle this work in FY 2004. Because some of the DMERC contractors still conduct Benefit Integrity activities, we may evaluate their performance of that function.

Mandated performance standards for intermediaries in the Payment Safeguards criterion are the accuracy of decisions on SNF demand bills, and the timeliness of processing Tax Equity and Fiscal Responsibility Act (TEFRA) target rate adjustments, exceptions, and exemptions. There are no mandated performance standards for carriers in the Payment Safeguards criterion. Intermediaries and carriers may also be evaluated on any Medicare Integrity Program (MIP) activities if performed under their agreement or contract.

The fourth criterion is ''Fiscal Responsibility'' which evaluates the contractor's efforts to protect the Medicare program and the public interest. Contractors must effectively manage Federal funds for both the payment of benefits and costs of administration under the Medicare program. Proper financial and budgetary controls, including internal controls, must be in place to ensure contractor compliance with its agreement with HHS and CMS.

Additional functions reviewed under this criterion may include, but are not limited to, adherence to approved budget, compliance with the Budget and Performance Requirements (BPRs), and compliance with financial reporting requirements.

The fifth and final criterion is ''Administrative Activities'' which measures a contractor's administrative management of the Medicare program. A contractor must efficiently and effectively manage its operations. Proper systems security (general and application controls), Automated Data Processing (ADP) maintenance, and disaster recovery plans must be in place. A contractor's evaluation under the Administrative Activities criterion may include, but is not limited to, establishment, application, documentation, and effectiveness of internal controls that are essential in all aspects of a contractor's operation, and the degree to which the contractor cooperates with us in complying with the Federal Managers' Financial Integrity Act of 1982 (FMFIA). Administrative Activities evaluations may also include reviews related to contractor implementation of our general instructions and data and reporting requirements.

We have developed separate measures for RHHIs in order to evaluate the distinct RHHI functions. These functions include the processing of claims from freestanding HHAs, hospital-affiliated HHAs, and hospices. Through an evaluation using these criteria and standards, we may determine whether the RHHI is effectively and efficiently administering the program benefit or whether the functions should be moved from one intermediary to another in order to gain that assurance.

Below, we list the criteria and standards to be used for evaluating the performance of intermediaries, RHHIs, carriers, and DMEPOS regional carriers.

IV. Criteria and Standards for Intermediaries

A. Claims Processing Criterion

The Claims Processing criterion contains the following six mandated standards:

Standard 1. Not less than 95.0 percent of clean electronically submitted non-Periodic Interim Payment claims are paid within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare intermediaries to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, clean, non-Periodic Interim Payment electronic claims can be paid as early as the 14th day (13 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 2. Not less than 95.0 percent of clean paper non-Periodic Interim Payment claims are paid within specified time frames. Specifically, clean, non-Periodic Interim Payment paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. The percentage of reconsideration determinations reversed by ALJs is acceptable. We have defined an acceptable reversal rate by ALJs as one that is at or below 5.0 percent.

Standard 4. 75.0 percent of reconsiderations are processed within 60 days, and 90.0 percent are processed within 90 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 5. 95.0 percent of Part B review determinations are completed within 45 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 6. 90.0 percent of Part B hearing decisions are completed within 120 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Because intermediaries process many claims for benefits under the Part B Medical Insurance portion of the Medicare Program, we also may evaluate how well an intermediary follows the procedures for processing appeals of any Part B claims.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Accuracy of claims processing.
- Establishment and maintenance of a relationship with Common Working File (CWF) Host.
- Accuracy of processing reconsideration cases.
- Accuracy of reviews and hearings, as well as the appropriateness of the reading level of any review determination letters.
- Accuracy and timeliness of processing appeals under section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA). See Note below.

Note: Section 521 of BIPA and section 940 of DIMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Upon implementation of section 521, the first level in a beneficiary's appeal will be a ''redetermination'' that will replace the current reconsideration for Part A appeals and the current review for Part B appeals. Intermediaries will be required to process all requests for redeterminations within 60 days of receipt of the request. Upon implementation of section 521 of BIPA, and section 940 of DIMA, we intend to begin evaluating whether intermediaries are meeting the timeliness and accuracy requirements for processing redeterminations. Because the ability for beneficiaries to request this new first level of appeal will not be initiated until section 521 of BIPA is implemented, there will be a period of time in which intermediaries will not only be processing redeterminations, but will continue to process the reconsideration, review, and hearing workloads that existed prior to the implementation of BIPA. Upon the implementation of section 521 of BIPA and section 940 of DIMA, this 60-day requirement and the processing accuracy will be additional functions that may be evaluated.

B. Customer Service Criterion

Functions that may be evaluated under this criterion include, but are not limited to, the following:

- Providing timely and accurate replies to beneficiary and provider telephone inquiries.
- Quality Call Monitoring.
- Training of Customer Service Representatives.
- Ensuring the validity of the call center performance data that are being reported in the Customer Service Assessment and Management System.
- Providing timely and accurate written replies to beneficiaries and providers that address the concerns raised and are written with an appropriate customer-friendly tone and clarity and that those written to beneficiaries are at the appropriate reading level.
- Walk-in inquiry service.

• Conducting beneficiary and provider education, training, and outreach activities.

• Effectively maintaining an Internet Website dedicated to furnishing providers and physicians timely, accurate, and useful Medicare program information.

C. Payment Safeguards Criterion

The Payment Safeguard criterion contains the following two mandated standards:

Standard 1. Decisions on SNF demand bills are accurate.

Standard 2. TEFRA target rate adjustments, exceptions, and exemptions are processed within mandated time frames. Specifically, applications must be processed to completion within 75 days after receipt by the contractor or returned to the hospitals as incomplete within 60 days of receipt.

Intermediaries may also be evaluated on any MIP activities if performed under their Part A contractual agreement. These functions and activities include, but are not limited to the following:

• Audit and Reimbursement

—Performing the activities specified in our general instructions for conducting audit and settlement of Medicare cost reports.

—Establishing accurate interim payments.

• Benefit Integrity

—Referring allegations of potential fraud that are made by beneficiaries, providers, CMS, Office of Inspector General (OIG), and other sources to the Payment Safeguard Contractor.

—Putting in place effective detection and deterrence programs for potential fraud.

• Medical Review

—Increasing the effectiveness of medical review activities.

—Exercising accurate and defensible decision making on medical reviews.

—Effectively educating and communicating with the provider community.

—Collaborating with other internal components and external entities to ensure the effectiveness of medical review activities.

• Medicare Secondary Payer

—Accurately reporting MSP savings.

—Accurately following MSP claim development and edit procedures.

—Auditing hospital files and claims to determine that claims are being filed to Medicare appropriately.

—Supporting the Coordination of Benefits Contractor's efforts to identify responsible payers primary to Medicare.

—Identifying, recovering, and referring mistaken/conditional Medicare payments in accordance with appropriate Medicare Intermediary Manual instructions and our other pertinent general instructions, in the specified order of priority.

• Overpayments

—Collecting and referring Medicare debts timely.

—Accurately reporting and collecting overpayments.

—Adhering to our instructions for management of Medicare Trust Fund debts.

• Provider Enrollment

—Complying with assignment of staff to the provider enrollment function and training the staff in procedures and verification techniques.

—Complying with the operational standards relevant to the process for enrolling providers.

D. Fiscal Responsibility Criterion

We may review the intermediary's efforts to establish and maintain appropriate financial and budgetary internal controls over benefit payments and administrative costs. Proper internal controls must be in place to ensure that contractors comply with their agreements with us.

Additional functions that may be reviewed under the Fiscal Responsibility criterion include, but are not limited to, the following:

• Adherence to approved program management and MIP budgets.

• Compliance with the BPRs.

• Compliance with financial reporting requirements.

• Control of administrative cost and benefit payments.

E. Administrative Activities Criterion

We may measure an intermediary's administrative ability to manage the Medicare program. We may evaluate the efficiency and effectiveness of its operations, its system of internal controls, and its compliance with our directives and initiatives.

We may measure an intermediary's efficiency and effectiveness in managing its operations. Proper systems security (general and application controls), automated data processing (ADP) maintenance, and disaster recovery plans must be in place. An intermediary must also test system changes to ensure the accurate implementation of our instructions.

Our evaluation of an intermediary under the Administrative Activities criterion may include, but is not limited to, reviews of the following:

• Systems security.

• ADP maintenance (configuration management, testing, change management, and security).

• Disaster recovery plan/systems contingency plan.

• Implementation of our general instructions.

• Data and reporting requirements implementation.

• Internal controls establishment and use, including the degree to which the contractor cooperates with the Secretary in complying with the FMFIA.

V. Criteria and Standards for Regional Home Health Intermediaries (RHHIs)

The following three standards are mandated for the RHHI criterion:

Standard 1. Not less than 95.0 percent of clean electronically submitted non-Periodic Interim Payment hospice claims are paid within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare intermediaries to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, clean, non-Periodic Interim Payment electronic claims can be paid as early as the 14th day (13 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 2. Not less than 95.0 percent of clean paper non-Periodic Interim Payment hospice claims are paid within specified time frames. Specifically, clean, non-Periodic Interim Payment paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. 75.0 percent of HHA and hospice reconsiderations are processed within 60 days and 90.0 percent are processed within 90 days. Our expectation is that contractors will meet this percentage on a monthly basis.

We may use this criterion to review an RHHI's performance for handling the HHA and hospice workload. This includes processing HHA and hospice claims timely and accurately; properly paying and settling HHA cost reports; and timely and accurately processing reconsiderations and BIPA section 521 redeterminations from beneficiaries, HHAs, and hospices.

Note: Section 521 of BIPA and section 940 of DIMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Upon implementation of section 521 of BIPA, the first level in a beneficiary's appeal will be a ''redetermination'' that will replace the current reconsideration for Part A appeals and the current review for Part B appeals. RHHIs will be required to process all requests

for redeterminations within 60 days of receipt of the request. Upon implementation of section 521 of BIPA and section 940 of DIMA, we intend to begin evaluating whether RHHIs are meeting the timeliness and accuracy requirements for processing redeterminations. Because the ability for beneficiaries to request this new first level of appeal will not be initiated until section 521 of BIPA are implemented, RHHIs will not only be processing redeterminations, but will continue to process the reconsideration, review, and hearing workloads that existed prior to the implementation of BIPA. Upon the implementation of section 521 of BIPA and section 940 of DIMA this 60-day requirement and the processing accuracy will be additional functions that may be evaluated.

VI. Criteria and Standards for Carriers

A. Claims Processing Criterion

The Claims Processing criterion contains the following six mandated standards:

Standard 1. Not less than 95.0 percent of clean electronically submitted claims are processed within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare carriers to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, clean electronic claims can be paid as early as the 14th day (13 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 2. Not less than 95.0 percent of clean paper claims are processed within specified time frames. Specifically, clean paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. 98.0 percent of MSNs are properly generated. Our expectation is that MSN messages are accurately reflecting the services provided.

Standard 4. 95.0 percent of review determinations are completed within 45 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 5. 90.0 percent of carrier hearing decisions are completed within 120 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 6. Review determination letters prepared in response to beneficiary initiated appeal requests are written at an appropriate reading level.

Additional functions that may be evaluated under this criterion includes, but are not limited to, the following:

- Claims Processing accuracy.
- Establishment and maintenance of relationship with the CWF Host.
- Accuracy of processing review determination cases.
- Accuracy of processing hearing cases with decision letters that are clear and have an appropriate customer-friendly tone.
- Accuracy and timeliness of processing appeals under BIPA.

Note: Section 521 of BIPA and section 940 of DIMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Upon implementation of section 521 of BIPA, the first level in a beneficiary's appeal will be a ''redetermination'' that will replace the current review for Part B appeals. Carriers will be required to process all requests for redeterminations within 60 days of receipt of the request. Upon implementation of section 521 of BIPA and section 940 of DIMA, we intend to begin evaluating whether carriers are meeting the timeliness and accuracy requirements for processing redeterminations. Because the ability for beneficiaries to request this new first level of appeal will not be initiated until section 521 of BIPA is implemented, there will be a period of time in which carriers will not only be processing redeterminations, but will continue to process the review and hearing workloads that existed prior to the implementation of BIPA. Upon the implementation of section 521 of BIPA and section 940 of DIMA, this 60-day requirement and the processing accuracy will be additional functions that may be evaluated.

B. Customer Service Criterion

Customer Service criterion contains the following mandated standard:

Standard. Replies to beneficiary correspondence address the beneficiary's concerns, are written with an appropriate customer-friendly tone and clarity, and are at the appropriate reading level.

Contractors must meet our performance expectations that beneficiaries and providers are served by prompt and accurate administration of the program in accordance with all applicable laws, regulations, and our general instructions.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Providing timely and accurate replies to beneficiary and provider telephone inquiries.
- Quality call monitoring.
- Training of customer service representatives.
- Providing timely and accurate written replies to beneficiary and provider inquiries.
- Ensuring the validity of the call center performance data that are being reported in the Customer Service Assessment and Management System.
- Walk-in inquiry service.
- Conducting beneficiary and provider education, training, and outreach activities.
- Effectively maintaining an Internet Website dedicated to furnishing providers timely, accurate, and useful Medicare program information.

C. Payment Safeguards Criterion

Carriers may be evaluated on any MIP activities if performed under their contracts. In addition, other carrier functions and activities that may be reviewed under this criterion include, but are not limited to the following:

- Benefit Integrity

—Referring allegations of potential fraud that are made by beneficiaries, providers, CMS, OIG, and other sources to the Payment Safeguard Contractor.

—Putting in place effective detection and deterrence programs for potential fraud.

- Medical Review

—Increasing the effectiveness of medical review activities.

—Exercising accurate and defensible decision making on medical reviews.

—Effectively educating and communicating with the provider community.

—Collaborating with other internal components and external entities to ensure the effectiveness of medical review activities.

- Medicare Secondary Payer

—Accurately reporting MSP savings.

—Accurately following MSP claim development/edit procedures.

—Supporting the Coordination of Benefits Contractor's efforts to identify responsible payers primary to Medicare.

—Identifying, recovering, and referring mistaken/conditional Medicare payments in accordance with the appropriate Medicare Carriers Manual instructions, and our other pertinent general instructions.

- Overpayments

—Collecting and referring Medicare debts timely.

—Accurately reporting and collecting overpayments.

—Compliance with our instructions for management of Medicare Trust Fund debts.

- Provider Enrollment

—Complying with assignment of staff to the provider enrollment function and training staff in procedures and verification techniques.

—Complying with the operational standards relevant to the process for enrolling suppliers.

D. Fiscal Responsibility Criterion

We may review the carrier's efforts to establish and maintain appropriate financial and budgetary internal controls over benefit payments and administrative costs. Proper internal controls must be in place to ensure that contractors comply with their contracts.

Additional functions that may be reviewed under the Fiscal Responsibility criterion include, but are not limited to, the following:

- Adherence to approved program management and MIP budgets.
- Compliance with the BPRs.
- Compliance with financial reporting requirements.
- Control of administrative cost and benefit payments.

E. Administrative Activities Criterion

We may measure a carrier's administrative ability to manage the Medicare program. We may evaluate the efficiency and effectiveness of its operations, its system of internal controls, and its compliance with our directives and initiatives.

We may measure a carrier's efficiency and effectiveness in managing its operations. Proper systems security (general and application controls), ADP maintenance, and disaster recovery plans must be in place. Also, a carrier must test system changes to ensure accurate implementation of our instructions.

Our evaluation of a carrier under this criterion may include, but is not limited to, reviews of the following:

- Systems security.
- ADP maintenance (configuration management, testing, change management, and security).
- Disaster recovery plan/systems contingency plan.
- Implementation of our general instructions.
- Data and reporting requirements implementation.
- Internal controls establishment and use, including the degree to which the contractor cooperates with the Secretary in complying with the FMFIA.

VII. Criteria and Standards for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carriers

The five criteria for DMEPOS regional carriers contain a total of seven mandated standards against which all DMEPOS regional carriers must be evaluated.

There also are examples of other activities for which the DMEPOS regional carriers may be evaluated. The mandated standards are in the Claims Processing and Customer Service Criteria. In addition to being described in these criteria, the mandated standards are also described in Attachment J–37 to the DMEPOS regional carrier statement of work (SOW).

A. Claims Processing Criterion

The Claims Processing criterion contains the following six mandated standards:

Standard 1. Not less than 95.0 percent of clean electronically submitted claims are processed within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare DMEPOS regional carriers to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, clean electronic claims can be paid as early as the 14th day (13 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 2. Not less than 95.0 percent of clean paper claims are processed within specified time frames. Specifically, clean paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. Properly generated 98.0 percent of MSNs. Our expectation is that MSN messages are accurately reflecting the services provided.

Standard 4. 95.0 percent of DMEPOS regional carrier review determinations are completed within 45 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 5. 90.0 percent of DMEPOS regional carrier hearing decisions are completed within 120 days. CMS's expectation is that contractors will meet this percentage on a monthly basis.

Standard 6. Review determination letters prepared in response to beneficiary initiated appeal requests are written at an appropriate reading level.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Claims processing accuracy.
- Review determinations and hearing decisions are written accurately, clearly, and in a customer friendly tone.
- Telephone reviews are appropriately documented and adjudicated timely.
- Requests for ALJ hearings are forwarded timely.
- Accuracy and timeliness of processing appeals under BIPA.

Note: Section 521 of BIPA and section 940 of DIMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Upon implementation of section 521 of BIPA, the first level in a beneficiary's appeal will be a ''redetermination'' which will replace the current review for Part B appeals. DMEPOS regional carriers will be required to process all requests for redeterminations within 60 days of receipt of the request. Upon implementation of section 521 of BIPA and section 940 of DIMA, we intend to begin evaluating whether DMEPOS regional carriers are meeting the timeliness and accuracy requirements for processing redeterminations. Because the ability for beneficiaries to request this new first level of appeal will not be initiated until section 521 of BIPA is implemented, there will be a period of time in which DMEPOS regional carriers will not only be processing redeterminations, but will continue to process the review and hearing workloads that existed prior to the implementation of BIPA. Upon the implementation of section 521 of BIPA and section 940 of DIMA, this 60-day requirement and the processing accuracy will be additional functions that may be evaluated.

B. Customer Service Criterion

The Customer Service Criterion contains the following mandated standard:

Standard. Replies to beneficiary correspondence, addresses concerns raised, writes with an appropriate customer-friendly tone and clarity at the appropriate reading level.

Contractors must meet our performance expectations that beneficiaries and suppliers are served by prompt and accurate administration of the program in accordance with all applicable laws, regulations, the DMEPOS regional carrier SOW, and our general instructions.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Providing timely and accurate replies to beneficiary and supplier telephone inquiries.
- Monitoring calls for quality.
- Training of Customer Service Representatives.

Ensuring the validity of the call center performance data that are being reported in the Customer Service Assessment and Management System.

- Providing timely and accurate replies to beneficiaries, providers, and suppliers.
- Maintaining walk-in inquiry service.
- Conducting beneficiary and supplier education, training, and outreach activities.
- Effectively maintaining an Internet Website dedicated to furnishing suppliers timely, accurate, and useful Medicare program information.
- Ensuring that communications are made to interested supplier organizations for the purpose of developing and maintaining collaborative supplier education and training activities and programs.

C. Payment Safeguards Criterion

DMEPOS regional carriers may be evaluated on any MIP activities if performed under their contracts. The DMEPOS regional carriers must undertake actions to promote an effective program administration for DMEPOS regional carrier claims. These functions and activities include, but are not limited to the following:

- Benefit Integrity

—Identifying potential fraud cases that exist within the DMEPOS regional carrier's service area and taking appropriate actions to resolve these cases.

—Investigating allegations of potential fraud made by beneficiaries, suppliers, CMS, OIG, and other sources.

—Putting in place effective detection and deterrence programs for potential fraud.

- Medical Review

—Reducing the error rate by identifying patterns of inappropriate billing.

—Educating suppliers concerning Medicare coverage and coding requirements.

- Medicare Secondary Payer

—Accurately reporting MSP savings.

—Accurately following MSP claim development/edit procedures.

—Supporting the Coordination of Benefits Contractor's efforts to identify responsible payers primary to Medicare.

—Identifying, recovering, and referring mistaken/conditional Medicare payments in accordance with the appropriate program instructions in the specified order of priority.

- Overpayments

—Determining that the DMEPOS regional carrier completely, accurately, timely, and aggressively pursued all outstanding overpayments in adherence with the Medicare Carriers Manual and CMS Program Memoranda resulting from the Debt Collection Improvement Act (DCIA).

—Verifying that all overpayments were timely and accurately recorded.

D. Fiscal Responsibility Criterion

We may review the DMEPOS regional carrier's efforts to establish and maintain

appropriate financial and budgetary internal controls over benefit payments and administrative costs. Proper internal controls must be in place to ensure that contractors comply with their contracts. Additional matters that may be reviewed under this criterion include, but are not limited to the following:

- Compliance with financial reporting requirements.
- Adherence to approved program management and MIP budgets.
- Control of administrative cost and benefit payments.

E. Administrative Activities

We may measure a DMEPOS regional carrier's administrative ability to manage the Medicare program. We may evaluate the efficiency and effectiveness of its operations, its system of internal controls, and its compliance with our directives and initiatives. Our evaluation of a DMEPOS regional carrier under this criterion may include, but is not limited to review of the following:

- Systems Security.
- Disaster recovery plan/systems contingency plan.
- Internal controls establishment and use, including the degree to which the contractor cooperates with the Secretary in complying with the FMFIA.

VIII. Action Based on Performance Evaluations

We evaluate a contractor's performance against applicable program requirements for each criterion. Each contractor must certify that all information submitted to us relating to the contract management process, including, without limitation, all files, records, documents and data, whether in written, electronic, or other form, is accurate and complete to the best of the contractor's knowledge and belief. A contractor is required to certify that its files, records, documents, and data have not been manipulated or falsified in an effort to receive a more favorable performance evaluation. A contractor must further certify that, to the best of its knowledge and belief, the contractor has submitted, without withholding any relevant information, all information required to be submitted for the contract management process under the authority of applicable law(s), regulation(s), contract(s), or our manual provision(s). Any contractor that makes a false, fictitious, or fraudulent certification may be subject to criminal and/or civil prosecution, as well as appropriate administrative action. This administrative action may include debarment or suspension of the contractor, as well as the termination or nonrenewal of a contract.

If a contractor meets the level of performance required by operational instructions, it meets the requirements of that criterion. When we determine a contractor is not meeting performance requirements, we will use the terms ''major nonconformance'' or ''minor nonconformance'' to classify our findings. A major nonconformance is a nonconformance that is likely to result in failure of the supplies or services, or to materially reduce the usability of the supplies or services for their intended purpose. A minor nonconformance is a nonconformance that is not likely to materially reduce the usability of the supplies or services for their intended purpose, or is a departure from established standards having little bearing on the effective use or operation of the supplies or services. The contractor will be required to develop and implement a PIP for findings determined to be either a major or minor nonconformance. The contractor will be monitored to ensure effective and efficient compliance with the PIP, and to ensure improved performance when requirements are not met.

The results of performance evaluations and assessments under all criteria applying to intermediaries, carriers, RHHIs, and DMEPOS regional carriers will be used for contract management activities and will be published in the contractor's annual Report of Contractor Performance (RCP). We may initiate administrative actions as a result of the evaluation of contractor performance based on these performance criteria. Under sections 1816 and 1842 of the Act, we consider the results of the evaluation in our determinations when—

- Entering into, renewing, or terminating agreements or contracts with contractors, and
- Deciding other contract actions for intermediaries and carriers (such as deletion of an automatic renewal clause). These decisions are made on a case-by-case basis and depend primarily on the nature and degree of performance. More specifically, these decisions depend on the following:

—Relative overall performance compared to other contractors.

—Number of criteria in which nonconformance occurs.

—Extent of each nonconformance.

—Relative significance of the requirement for which nonconformance occurs within the overall evaluation program.

—Efforts to improve program quality, service, and efficiency.

—Deciding the assignment or reassignment of providers and designation of regional or national intermediaries for classes of providers.

We make individual contract action decisions after considering these factors in terms of their relative significance and impact on the effective and efficient administration of the Medicare program.

In addition, if the cost incurred by the intermediary, RHHI, carrier, or DMEPOS regional carrier to meet its contractual requirements exceeds the amount that we find to be reasonable and adequate to meet the cost that must be incurred by an efficiently and economically operated intermediary or carrier, these high costs may also be grounds for adverse action.

IX. Regulatory Impact Statement

We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million in any one year). Since this notice only describes criteria and standards for evaluating FIs (including RHHIs), carriers, and DMEPOS regional carriers and has no significant economic impact on the program, its beneficiaries, providers or suppliers, this is not a major notice.

The RFA requires agencies to analyze options for regulatory relief of small businesses, but intermediaries, RHHIs, carriers and DMEPOS regional carriers are not small businesses.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This notice does not affect small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. In accordance with section 202, we have determined that the notice does not impose any unfunded mandates on States, local or tribal governments, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a notice that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have determined that the notice does not significantly affect the rights, roles, and responsibilities of States.

We have not prepared a Regulatory Impact Analysis for this notice, in accordance with Executive Order 12866, because it will not have a significant economic impact, nor does it impose any unfunded mandates on State, local, or tribal governments or the private sector. Furthermore, we certify that the notice will not have a significant impact on a substantial number of small entities or small rural hospitals.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

X. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Authority: Sections 1816(f), 1834(a)(12), and 1842(b) of the Social Security Act (42 U.S.C. 1395h(f), 1395m(a)(12), and 1395u(b)).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital

Insurance, and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 5, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Editorial Note. This document was received at the Office of the Federal Register on December 17, 2003.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1254–N]

Medicare Program; Meeting of the Advisory Panel on Ambulatory Payment Classification Groups—February 18, 19, and 20, 2004

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of meeting.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act (FACA) (5 U.S.C. Appendix 2), this notice announces the first biannual meeting of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) for 2004.

The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary of Health and Human Services (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) (the Administrator) concerning the clinical integrity of the APC groups and their associated weights. The Secretary and Administrator consider the Panel's advice as CMS prepares its annual updates of the hospital outpatient prospective payment system (OPPS) through rulemaking.

DATES: The first biannual meeting for 2004 is scheduled for February 18, 19, and 20, 2004, from 8 a.m. to 5 p.m. (EST).

ADDRESSES: The meeting will be held in the Multipurpose Room, 1st Floor, at the CMS Central Office, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: For copies of the charter, inquiries regarding these meetings, meeting registration, and submission of oral presentations or written agenda items, contact Shirl Ackerman-Ross, the meeting coordinator and Designated Federal Official, FACA; CMS, Center for Medicare Management, Hospital Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard, Mail Stop C4–05–17; Baltimore, MD 21244–1850 or phone (410) 786–4474. Also, please refer to the CMS Advisory Committees' Information Line at 1–877–449–5659 (toll free) and (410) 786–9379 (local).

For additional information on the APC meeting agenda topics and/or updates to the Panel's activities, search our Internet Web site: *http://www.cms.hhs.gov/faca/apc/default.asp*.

To submit a request for a copy of the charter, search the Internet at *http://www.cms.hhs.gov/faca* or e-mail *SAckermannross@cms.hhs.gov*.

Written materials may also be sent electronically to *outpatientpps@cms.hhs.gov*.

News media representatives should contact our Public Affairs Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary of the Department of Health and Human Services (the Secretary) is required by section 1833(t)(9)(A) of the Social Security Act (the Act) to establish and consult with an expert, outside advisory panel on Ambulatory Payment Classification (APC) groups. The Advisory Panel on Ambulatory Payment Classification Groups (the Panel) meets up to three times annually to review the APC groups and to provide technical advice to the Secretary and to the Administrator of the Centers for Medicare & Medicaid Services (CMS) (the Administrator) concerning the clinical integrity of the groups and their associated weights. We will consider the technical advice provided by the Panel as we prepare the proposed rule that proposes changes to the Outpatient Prospective Payment System (OPPS) for the next calendar year.

The Panel may consist of a chair up to 15 members. These members must be representatives of Medicare Providers who are subject to OPPS and they may not be consultants. Panel members must have technical expertise that will enable them to participate fully in the work of the panel and must be currently employed full-time in their area of expertise. The Administrator selected the Panel membership based upon either self-nominations or nominations submitted by providers or organizations.

The Panel presently consists of the following members and a Chair (Vacant):

- Marilyn Bedell, M.S., R.N., O.C.N.
- Geneva Craig, R.N., M.A.
- Lora DeWald, M.Ed.
- Albert Brooks Einstein, Jr., M.D.
- Robert E. Henkin, M.D.
- Lee H. Hilborne, M.D., M.P.H.
- Stephen T. House, M.D.
- Frank G. Opelka, M.D., F.A.C.S.
- Kathleen Kinslow, C.R.N.A., Ed.D.
- Mike Metro, R.N., B.S.
- Gerald V. Naccarelli, M.D.
- Beverly K. Philip, M.D.
- Lynn R. Tomascik, R.N., M.S.N., C.N.A.A.
- Timothy Gene Tyler, Pharm.D.
- William Van Decker, M.D.

The agenda for the February 2004 meeting will provide for discussion and comment on the following topics:

- Reconfiguration of APCs (for example, splitting of APCs, moving Healthcare Common Procedure Coding System (HCPCS) codes from one APC to another and moving HCPCS codes from New Technology APCs to Clinical APCs).
- Evaluation of APC weights.
- Packaging devices and drug costs into APCs: methodology, effect on APCs, and need for reconfiguring APCs based upon device and drug packaging.
- Removal of procedures from the inpatient list for payment under the OPPS.
- Use of single and multiple procedure claims data.
- Packaging of HCPCS codes.
- Other technical issues concerning APC structure.

We are soliciting comments from the public on specific agenda items falling within these agenda topics for the February 2004 Panel meeting. We will consider specific agenda items for this meeting if they are submitted in writing and fall within the agenda topics listed above. We urge those who wish to comment to send comments as soon as possible but no later than 5 p.m. (EST), Friday, February 6, 2004.

The meeting is open to the public, but attendance is limited to the space available. Individuals or organizations wishing to make 5-minute oral presentations should contact the meeting coordinator by 5 p.m. (EST), Friday, February 6, 2004, in order to be scheduled. The number of oral presentations may be limited by the time available. Oral presentations must not exceed 5 minutes and may be further limited by the Chair due to quantity of presentations.

Persons wishing to make oral presentations must submit a copy of the presentation and the name, address, and telephone number of the presenter. In addition, all presentations must contain, at a minimum, the following supporting information and data: